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Editorial

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We live in an era of increasing reliance on psychotropic drugs. In particular, antidepressants, such as the Specific Serotonin Reuptake Inhibitors (SSRIs), are among the most widely used of all prescription drugs. A 2004 study conducted by the Centers for Disease Control reported that 10% of American women and 4% of American men now take antidepressants.

Although the SSRIs were initially conceived as a treatment for depression per se, they are now expanding into additional markets, so that they are increasingly prescribed for a variety of ailments including anxiety, panic attack, obsessive-compulsive disorder, alcoholism, drug addiction, and eating disorders. In addition, the last decade or so has seen their use substantially extended from the adult population into school age and even preschool children.

This "Prozac mania" has generated both exuberance and condemnation in the public sphere, as evidenced in numerous popular articles and books. Notable among these are the best-selling "Listening to Prozac" by Peter Kramer (Penguin, 1997), which exalts the benefits of SSRIs, suggesting that they may have the ability to make many of us "better than well". Alternatively, concerns over dangerous side effects, as well as philosophical concerns related to the idea of finding happiness in a pill, have also prompted cautionary popular works such as "Let them Eat Prozac" by David Healy (New York University Press, 2004) and "The Prozac Backlash" by Joseph Glenmullen (Simon and Schuster, 2000).

The scientific evidence to support the use (and FDA approval) of these drugs comes primarily from Randomized Controlled Trials, which are considered to be the gold standard for testing drug efficacy and safety. This type of study has several key features designed to ensure unbiased assessment of the drug effect. First, the study participants are randomly assigned to either a treatment (active drug) or placebo condition. Additionally, this assignment is kept secret from both the patient and the treating physician (i.e., the study is "double blind"). Thus, in principle, no biases can be introduced either because of preferential assignment of certain types of patients to the placebo versus treatment group, or because of patient or physician expectations about the drug efficacy. In addition, symptom assessment before and during the drug treatment is typically accomplished, at least in part, through the use of standard, objective tests such as the Hamilton Depression Scale. This presumably eliminates idiosyncrasies that could be introduced by individual interviewers' styles.

This use of Randomized Controlled Trials would seem to provide for logically unassailable conclusions regarding drug efficacy. Any statistically significant differences between the drug and placebo groups must be caused by the active drug ingredient itself.

In the position piece that follows, Cohen and Jacobs provide detailed criticism of these procedures. They question whether the studies are truly "blind", and they also challenge the use of so-called objective test proce-

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dures, which leave out any personal voice of the patients themselves, do not allow for assessment of the full range of psychoactive effects of the drugs, and may allow for underreporting of adverse drug effects.

It should be noted that it was originally our intention to present an accompanying paper to provide the opposing view on this issue. Specifically, we made efforts to solicit a paper defending the legitimacy of the empirical work using Randomized Controlled Trials to demonstrate the efficacy and safety of the SSRIs. However, our efforts in this were unsuccessful. We encourage readers to contribute to this aspect of the debate.